Tree of Life: Acceptability and feasibility with older Bosnian women of refugee background

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Australia resettled up to 19,000 displaced Bosnians in the early 1990s, after the war in Bosnia (Colic-Peisker & Walker, 2003). Most were Muslims who had been subjected to persecution, trauma, torture, and violence and had witnessed the murder of loved ones (Paunovic & Öst, 2001). A number of these individuals, who migrated as adults, form a population that requires greater medical attention considering added psychosocial, cognitive, and physical challenges associated with the ageing process (Jeste et al., 2010). Further, these challenges are more complex for culturally diverse women and those from a refugee background (Slewa-Younan et al., 2016). Therefore, it is important to identify therapeutic and counselling programs that can be used with these subgroups of the population.

Former Bosnian Refugees in Australia

The war in the former Yugoslavia occurred in Bosnia and Herzegovina ("Bosnia") from 1992 to 1995. In a population of 4 million, over 2 million citizens were displaced with up to half a million people fleeing to other countries (Phuong, 2000). The Bosnian population experienced war atrocities, which were described as "by far the worse savagery" seen in Europe since World War II (Spasojevic et al., 2000, p. 206). These experiences included loss of loved ones, physical assault, daily bombings, rape, witnessing death or rape of loved ones, betrayal from family and friends due to religion or ethnicity, and extreme hunger and/or thirst. Approximately 100,000 people were killed by 1995 with 80% of them being Muslim (Hawton, 2009). Many were granted temporary asylum in European countries. They later returned to Bosnia or permanently resettled in overseas countries such as the United States, Canada, New Zealand, and Australia.

Bosnian refugees resettled in Australia did so under government-sponsored humanitarian programs (Kartal et al., 2018). Upon arrival, they received permanent residency and unrestricted access to welfare, healthcare, language training, housing, and vocational support (Kartal et al., 2018). There were also opportunities to bring their family members to live in Australia. Atrocities of war led to depression, anxiety, complicated grief and loss, posttraumatic stress disorder (PTSD), and other trauma-related disorders (Kartal et al., 2018; Momartin et al., 2004). Further, PTSD was significantly higher and more complex among older Bosnian refugees than younger refugees (Weine et al., 1998). Kartal et al.

(2018) found that Bosnians of refugee background, who had been settled in Australia for an average of 18 years, still displayed symptoms consistent with PTSD and anxiety. These results indicate that distress symptoms can remain for decades after the experience of a traumatic event. The ageing process may further compromise overall health and quality of life, with an increase of physical ailments and a decrease of physical mobility, attention, and memory functioning (Kristiansen et al., 2016). Ageing can also impact cognition in other ways, including reduction in mental flexibility, concept formation, or ability to abstract (Lezak et al., 2012).

There is growing evidence to support people who have experienced trauma and forced displacement with psychological interventions (Uphoff et al., 2020). Most of this research has been driven by evidence-based cognitive behavioural therapy (CBT) models, which frequently include medication, psychoeducation, cognitive processing, trauma narrative, exposure, and strategies to increase relaxation and adaptive coping (Buhmann et al., 2018; Chipalo, 2021; Unterhitzenberger et al., 2021). Researchers and clinicians are expressing an interest in modifying and enhancing the cultural sensitivity and safety of these programs used with refugees (Ennis et al., 2020). There are concerns that traditional approaches may not address the varied experiences and psychological reactions of people of refugee background (Silove et al., 2019). Moreover, attempts to have conversations about trauma may retraumatise the individual (Vitale et al., 2019). Considering these challenges, alternative psychosocial interventions are being explored.

Literature highlights an emerging body of research, which focuses on creative, expressive, and strength-based approaches to assist populations from a refugee background (Khawaja et al., 2022). Instead of depending on conversations about past adversities, therapists tend to use indirect methods such as art, dance, and physical activity to process the traumatic experiences of people from refugee backgrounds (Nordbrandt et al., 2020; Kalmanowitz & Rainbow, 2016; Rowe et al., 2017; Serlin, 2021). Storytelling has been incorporated as a strategy to enhance meaning-making (De Haene et al., 2018; Wright et al., 2020). Modalities such as narrative therapy take a strengths-based, client-centred stance and use tools and strategies to allow clients to explore their own skills and potential to address challenges. Clients are regarded as the expert of their own lives. In these cases, therapists contextualise the experiences of people from a refugee background while also acknowledging the important role of culture, values, strengths, and resilience (Silove et al., 2017).

Tree of Life

Tree of Life (TOL) is a psychosocial strengths-based group intervention founded on creative/expressive and narrative therapy concepts (White & Denborough, 1998). Ncazelo Ncube, a trauma counsellor and narrative therapist, developed TOL while working with traumatised children in Southern Africa (2006). These children had encountered multiple traumas, such as living with HIV and losing parents due to HIV/AIDS. Denborough (2008) joined forces with Ncube to further use the program with vulnerable Indigenous children in Australia. Since then, the approach has been used in

many parts of the world. Using a tree as a metaphor for their life, individuals are invited to draw a tree over a few sessions. Taking a curious approach, the therapist asks individuals to comment about the different parts of the tree and facilitates group discussion. Various parts of the tree reflect the person's life. Roots highlight an individual's origin, ancestry, values, and valuable memories. Ground amplifies present life and activities. The tree's trunk identifies a person's skills and abilities. Branches highlight an individual's future hopes, dreams, and wishes. Leaves and fruit reflect significant people from one's life and gifts of love and kindness that a person receives from others. Therapists and group members listen to everyone's accounts respectfully. The group members join their trees to form a forest, which leads to a discussion about a storm in a forest and its impact on the trees. Storms symbolise challenges that people may experience in their lives. Finally, revival of life in the forest after the storm encourages participants to reflect on how people can rebuild their lives after adversities. Drawings are used to highlight the inherent strengths of individuals.

The therapist's curious approach and the opportunity to share adversities slowly through drawings and group discussions allow for cultural safety and sensitivity (Vitale et al., 2019). Metaphors and questions inspire individuals to tell their stories in a way that empowers them, while the group process allows them to hear stories of hope, strength, and shared values, which can help individuals reauthor their stories to preferred ways of living (Lock, 2016). Researchers Carey and Russell (2003) and Schweitzer et al. (2014) have identified five narrative principles that underlie TOL: it explores alternative stories of self; enhances group cohesion and relational belonging; provides corrective emotional experiences; allows outsider witnesses to acknowledge and validate new self-stories and narratives; and instils hope for the future. Practice-based anecdotes suggest that TOL has shown positive outcomes with various populations, including students in the United Kingdom (Nolte et al., 2016), staff in a palliative care setting (Nolte et al., 2016), adult trauma survivors (Reeler et al., 2009), and young Indigenous Australians (White & Denborough, 1998). Reported outcomes included improved coping and change in perspective (Reeler et al., 2009), and increased confidence in talking about and coping with emotional difficulties (Nolte et al., 2016).

TOL has demonstrated effectiveness when trialled with at-risk children and adults of refugee background (German, 2013; Hughes, 2014). When used with primary school children from refugee backgrounds in the United Kingdom, it led to improvement in their self-concept and ability to understand their own selves and other children in the class (German, 2013). Class teachers also reported that students' behaviour and peer relationships improved. Hughes (2014) used TOL with a group of Afghan mothers from refugee backgrounds in the United Kingdom. After completion, these mothers reported an increase in their confidence and ability to manage and support their children. They felt less isolated and recognised religion and ethnicity were sources of strength (Hughes, 2014). Schweitzer et al. (2014) used TOL with a group of Liberian adolescents resettled in Australia on a humanitarian basis. They found improved peer relationships and socialisation, increased confidence, and better teacher-reported classroom functioning (Schweitzer et al., 2014). Recent research in the United Kingdom found that former

refugee women living with HIV learnt to manage loss and grief by becoming aware of their strengths, future aspirations, and hopes (Vitale et al., 2019). Participants began to build, enrich, and strengthen their own preferred self-narratives. While these studies highlight benefits of TOL with adults and children from refugee backgrounds, they did not explore the benefits and process of TOL for older adults. This is an important gap in the literature.

Barriers to Accessing Care

Although there are a number of government and non-government services for refugees in Australia, uptake is low (Silove et al., 2017). Poor use of mental health services can be due to prior experiences of abuse of power by authority figures (Ellis et al., 2011), fear of discrimination (Asgary & Segar, 2011), lack of familiarity with the settlement country's healthcare system (Asgary & Segar, 2011; Gould et al., 2010), difficulty navigating the complex healthcare system (Asgary & Segar, 2011), and language barriers (Ellis et al., 2011; Kaplan et al., 2016; Satinsky et al., 2019). Refugees' stigma and attitudes towards mental health is another barrier to accessing support (Jankovic et al., 2011; Kaplan et al., 2016; Shannon et al., 2015). Stigma associated with mental health is common in Bosnian culture and communities (Hasanovic et al., 2006). In the former Yugoslavia, outpatient mental health care was uncommon, and mental health services were mostly inpatient and focused on schizophrenia (Mooren & Kleber, 1999). Schulz et al. (2006) found that Bosnians felt ashamed of needing and accessing mental health care.

One strategy to decrease the stigma accompanying mental health services is to incorporate interventions into community-based settings, such as community and resettlement services (Satinsky et al., 2019). Interventions in community-based settings empower individuals (Harpham & Few, 2002) and address refugees' perceived stigma of traditional mental health services (Jacobs, 2018). Community-based psychosocial programs can play an important role in fostering social connections both within and between communities (Slewa-Younan et al., 2018), establishing a sense of control, and increasing self and collective worth (Hirschberger, 2018; Slewa-Younan et al., 2018). Providing community-based interventions to Bosnian refugees is particularly important considering that some may not be comfortable with traditional medical and inpatient settings for mental health treatment (Jankovic et al., 2011; Weine et al., 2008).

Despite the documented benefits of individual therapy (Thompson et al., 2018), the evidence indicates that a number of refugees are not inclined to seek individual therapy or other formal mental health services (Jankovic et al., 2011; Weine et al., 2008). Thus, a group format is another method to decrease stigma and increase the uptake of services (Pfeiffer et al., 2019; Zehetmair et al., 2018). Group-based therapy has been shown to be effective (Eskici et al., 2021; Hutchinson et al., 2022) and may be particularly important when there are significant mental health shortages and waitlists for services. Group programs offer opportunities for social contact and mutual support, with members feeling empowered by experiencing themselves as a helper and not a victim (Van der Kolk,

2003). Further, it is vital that these interventions are culturally adapted (Silove et al., 2019), and that mental and allied health professionals recognise the importance and benefit of cultural humility in therapy (Zhang et al., 2021).

Aim of the Present Study

TOL is an alternative to traditional mental health services provided for people from a refugee background (Hughes, 2014). While there are many barriers to refugees accessing mental health services, TOL can help overcome barriers related to stigma, particularly when implemented in community-based settings. Given the reported difficulties faced by Australian Bosnians from refugee backgrounds, the current study explored the impact of TOL on older Bosnian women who were former refugees. Further, acceptability and feasibility of implementing TOL with this specific population was considered.

Method

Setting

The study was conducted at the Islamic Women's Association of Australia (IWAA), a not-for-profit organisation in Queensland, Australia. IWAA offers aged care and disability support for women, settlement services for newly arrived families, and shelter for culturally and linguistically diverse (CALD) women experiencing domestic violence. Further, IWAA offers older women, who may otherwise be isolated, an opportunity to socialise at weekly drop-in sessions. IWAA offers subsidised food and transport to and from the venue for those who require it. Seminars and workshops on various topics (e.g., religion, living skills, health education) are also offered.

Participants

Five women, who moved to Australia from Bosnia, participated. Their mean age was 72 years (*SD* = 12). All had been living in Australia for between 14 and 23 years and identified as Muslims. All participants spoke Bosnian at home, with two indicating they had no difficulty with the English language, one indicating some difficulty, and two indicating they had great difficulty. All were citizens or permanent residents of Australia. Three had completed high school, while two had completed vocational diplomas. All were retired or unemployed. Two participants were single, two were widowed, and one was married. All participants reported a fractured family unit because of the war. They all fled Bosnia and took refuge in a European country before relocating to Australia.

Procedure

This study was part of a larger study exploring the application of TOL on varied populations across different settings (Khawaja et al., 2022). Ethical clearance was obtained from the Queensland University of Technology Human Research Ethics

Committee. IWAA disseminated information about the study to members. The researchers also visited IWAA on numerous occasions to provide more information about the project and introduce themselves to staff and prospective participants. Of the women from a Bosnian background, five expressed an interest to participate. All oral and written communication occurred with the help of an interpreter. Participants were informed about the study and provided written informed consent. A manual-based TOL was facilitated (Vromans et al., 2013), with process and outcome assessments occurring before, during, and following the intervention. The content of the 6-week TOL, outlined in Table 1, was covered in weekly 60-minute sessions. One participant missed one session, and two participants missed two sessions due to health issues. The women were invited to provide feedback at the end of each session. Two facilitators (second and third authors) implemented the program with the help of a bilingual interpreter fluent in English and Bosnian. The first author and another member of the larger team, who had minimal prior interaction with the participants, facilitated the postintervention focus group. All women were invited to take part in the postintervention interview. Three women agreed and were interviewed by the third author.

Table 1. Content of Weekly Tree of Life sessions

Week	Content
1	**Home, belonging and trees.** A therapeutic relationship was established to assist participants develop a rich understanding of “home” and “belonging” for themselves and others. Trees were also introduced as metaphors to externalise conversations.
2	**The roots and ground.** As part of the roots, participants were asked to consider their origins, family history, and what kept them steady. The ground referred to their current daily activities and was introduced to help create a feeling of continuity between their past and present.
3	**The trunk and branches**. The trunk was introduced to explore participants’ skills, values, and special memories. The branches referred to hopes, dreams, and wishes for the future. Participants’ awareness in what they valued helped with meaning-making and eliciting strengths.
4	**The leaves and fruits.** Leaves were introduced to represent people in participants’ past and present who were important to them. Fruits referred to gifts they had given and received. This session built upon the previous session where participants reflected on their skills and values. A sense of relatedness and honouring the contribution of others in participants’ lives was fostered.

5	**The forest of life and storms.** Trees of all participants were brought together to form the “forest of life”. The metaphor of the forest was introduced to represent the connectedness between participants (the “individual trees”) and others (the “forest”). The metaphor of storms and life after a storm was used to help participants reflect upon hardship and adversity and how to address these challenges.
6	**Celebration and certificates.** Participants’ contributions to TOL were acknowledged to honour their lives, skills, and values. Certificates of completion and small gifts were awarded.

Materials

Demographics

A form was used to collect information about age, gender, relationship status, country of birth, language spoken most often, religion, duration of stay in Australia, country lived in before Australia, residency status, English skills, highest level of education, and employment.

Process Evaluation

Feedback forms, developed by the authors, were used to determine what participants liked or disliked about each session. Facilitators also completed a form, which included prompts such as: what participants seemed to enjoy; were least satisfied with; what was a success; what may need to change; significant events that occurred during the session; and how these were managed. Facilitators also completed a checklist, which summarised key elements of each session. It was completed in each session to check the fidelity of delivery. An overall percentage, based on how much of the overall checklist was adhered to, was calculated.

Postintervention Focus Group and Interviews

A focus group and interviews were conducted at the end of TOL to understand participants’ experiences of the program. Questions relating to acceptability, feasibility, and participants’ experiences of TOL were used.

Data Analysis

A qualitative methodology with multiple modes of data collection was used to evaluate the acceptability and feasibility of TOL. TOL feasibility was assessed using a framework developed by Bowen et al. (2009). They suggested multiple focus areas when assessing feasibility, with the relevant areas in this study being acceptability and implementation.

Acceptability was assessed using participants' feedback, as well as the researchers' observations to determine the extent to which participants considered the program appropriate and satisfying. Treatment fidelity and researchers' observations were used to assess implementation, which refers to the extent that a new program can be successfully delivered to intended participants in a defined, but not completely controlled, context (Bowen et al., 2009).

Qualitative data was analysed using a thematic analysis framework drawn from Braun and Clarke (2006). Participants' comments in general and those added to the drawings were reviewed multiple times. Facilitators' notes were reviewed multiple times to search for word and phrase repetitions. Based on the repeated words and phrases, salient themes were identified by the first and third authors. These themes were then interpreted by the second author. Finally, the team met as a group to review the themes and merge them into overarching major themes. The facilitators' notes provided the level of detail needed for the scope of this study in assessing feasibility and acceptability and avoided the challenges of using audio recordings, which can be a barrier to research with some cultural groups (Kaplan et al., 2016; van Loenen et al., 2017). The research team adopted a reflexive approach to identify and respond to potential biases within the evaluation (Palaganas et al., 2017). The research team, which consisted of two CALD and one migrant Caucasian facilitator, had regular and open conversations about the experiences within the context of their own diverse backgrounds and interpretation of the findings.

Results

Acceptability and Feasibility

The delivery and content of TOL supported feasibility. The 60-minute duration of sessions was deemed appropriate by this group due to their age, fatigue, and health issues. The community centre was deemed appropriate as participants were accustomed to attending services there. The fidelity checklist indicated that facilitators were able to adhere to the manual. They were successful in executing the intervention in an informal setting. TOL did not require extensive resources and appeared to be a feasible intervention for the intended participants of this study. Acceptability was evidenced by the women's willingness to participate in TOL as no one withdrew from the program. Sessions were missed due to reported health reasons. All participants stated multiple times that they were satisfied with TOL and expressed an interest in participating in similar programs. They also expressed their gratitude multiple times to the facilitators. This indicated a high acceptability for community-based psychosocial approaches.

The Participants' Experience of TOL

Participants reported that they enjoyed sharing their journeys and experiences of settling in Australia. They all agreed that it took time to adjust to a very different life in an urban setting. They felt closer to each other based on similar experiences. When discussing home and their sense of belonging, most participants indicated that they viewed both

Bosnia and Australia as home. There was unanimous agreement that home was associated with family. One participant, who had lost multiple family members in Bosnia because of war, expressed that she could not view Bosnia as her home any more. She also shared advice she received from a health professional to try to forget about Bosnia and the events that occurred there. This was upsetting for other participants, who tried to convince her why Bosnia should be home.

Participants' roots were focused on their country of origin as well as the countries they lived in before migrating to Australia. All participants included past and present friends and family members as part of their roots. Family was also an important aspect of their ground, as spending time with family was an integral part of their current daily activities. Further, when using trunks as a metaphor for their strengths, the participants discussed cooking, baking, and gardening. Love for their family and their ability to provide nourishment to family members were perceived as strengths. When drawing their branches and identifying their hopes, the participants' hopes and dreams mostly revolved around wanting the best for their families. Participants also reported wanting to go to the shops or the beach, and to visit family and friends.

Participants all identified the love of family as the best gift they had received. They all agreed that giving love to family was the best gift they could give. They appeared to enjoy sharing the names of the people they placed on their tree and reasons why those people were placed there. One participant became teary as she mentioned she had not seen her son, who was living overseas, in some time. Other participants comforted her and spoke reassuringly to her. Another participant acknowledged the strength the distressed participant had while being away from her son.

Participants pinned their drawings on the wall to signify the forest of life. They reflected that it was "nice" to see themselves, their families, and supports come together. They shared that they felt at peace being part of the forest, with one participant describing that she experienced being part of the forest as "nourishing". Two other participants shared stories of the mountains and trees they used to live near in Bosnia, and how the forest of life reminded them of their childhood home.

When discussing storms as a metaphor for difficult periods in life, the participants acknowledged that it was rare to not experience storms. They discussed the importance of providing support and sharing resources with others during storms. One participant shared a Bosnian proverb which translated to "when it is cold, the cat and mouse sleep together". They shared that once storms have passed, they can "relax" and "be happy". The completion of TOL was celebrated. Participants acknowledged each other's contributions and reflected positively on the past 6 weeks. After outcome measures were completed, certificates and gifts were presented to participants at a ceremony in which other members of IWAA were present.

Facilitators' Reflections

Facilitators noted that participants' Bosnian heritage was a strong part of their identity. However, they desired acknowledgement and understanding of their individual experiences. Due to varying pre-migration experiences, there was a difference of opinion on how "loyal" one should be to Bosnia. All participants used multiple pages to draw plants, people, houses, and flowers. It appeared drawing was an engaging and non-confronting way for these participants to share and reflect on their stories. Initially, the participants experienced some difficulty in identifying personal strengths. It appeared the concept was unfamiliar to them or that having strengths was something they had never considered. Participants related their strengths to their family and saw themselves as loving and nurturing mothers and grandmothers. Their hopes for the future revolved around their children and grandchildren more than themselves, suggesting that their family played an integral role in their self-narratives. The participants' wishes for themselves revolved around the immediate rather than the distant future. While their focus on the immediate future may reflect their age, it may also reflect a tendency to remain focused on the present more so than the future.

Although drawing was the most preferred activity for the participants, facilitators also observed some challenges. Facilitators developed almost all the group rules due to minimal input from participants in generating rules. There appeared to be difficulty in understanding metaphors and engaging in abstract conversations such as "tree" as a symbol of life and "storms" as a symbol of hardships. With the help of the interpreter, these abstract concepts and metaphors were explained by the facilitators several times. Once the concepts were understood, participants responded to the cues and shared their personal experiences. There was a time constraint, and the 1-hour session was not adequate for the content, yet the women appeared fatigued and ready to finish at the end of 1 hour. The room setting was rather informal, which made it difficult for the organisation to see it as a formal therapeutic activity. The general noise in the centre distracted the facilitators; however, participants reported not being affected by it.

Postintervention Focus Group and Interviews

Satisfaction

Participants indicated that they found the intervention interesting. They described TOL as "successful and fun", noting they were "happy drawing and sitting with others". The participants found discussions "very interesting" and liked remembering where they came from. Participants indicated that they particularly enjoyed thinking about their families, including those in Bosnia, and placing these family members on their trees. One participant indicated that TOL made her feel comfortable and "at peace" talking about relatives whom she had not seen in over 25 years. Participants also indicated that settling in Australia helped them feel "peace" and comfortable to talk about everything.

Perceived Benefits

Participants indicated that TOL provided them the opportunity to express themselves and reminisce about people and places from their past. They described that although they had family and friends, they normally did not have a chance to talk about their past. They indicated that it was good to remember their past. They saw drawing as a safe way to express their feelings (“Drawing allowed me to express how I was feeling when I could not express the feelings aloud”). They also talked about their postmigration experiences (“Coming to Australia was like a new life”) which they saw as a “new beginning”. They recognised that the tree represented their lives with their families and family support (“My family members are always there for each other”).

The participants found the non-judgmental approach helpful (“I was judged previously for talking about my family and children, and I did not feel judged during TOL . . . TOL gave me the opportunity to be heard”). The group process fostered social and emotional support (“I feel I belong with other participants and feel familiar with the others”). Validation by fellow members was appreciated (“It was really good for the women to recognise each other better”). The therapeutic element of the process was endorsed (“TOL had opened my mind and it was like seeing a psychologist”). There was an overwhelming desire to continue their friendships. They shared that they felt thankful that the facilitators provided an opportunity to talk and listen.

Suggestions

Participants reported there were no aspects of TOL they did not like or that should be changed. They expressed interest in participating in similar programs, particularly groups related to health and wellbeing. Participants believed IWAA was an appropriate venue for TOL. They appreciated IWAA’s efforts to bring women together and requested similar events in the future (“I would like to participate in more groups to do with happiness”). They also thought the duration of sessions, and frequency and length of TOL, were appropriate. The participants indicated they would miss the facilitators.

Discussion

The present study examined whether the TOL intervention in a community-based setting was beneficial for older women from Bosnian refugee backgrounds. The qualitative findings highlighted TOL to be a feasible intervention; participants accepted it and some therapeutic factors promoted change.

The community setting addressed barriers such as travel costs, proximity to the service, and stigma associated with mental health settings (Jankovic et al., 2011; Kaplan et al., 2016). These findings emphasise the importance of using psychosocial approaches and taking services out of traditional health clinics to places where potential consumers already feel comfortable and familiar. The importance of modifying interventions to fit ongoing programs within services like IWAA was highlighted. Nevertheless, it is important to be mindful of privacy, confidentiality, and the tailoring of the group to the specific context when planning to facilitate TOL in less formal settings.

Consistent with previous research, participants found the program enjoyable and therapeutic (Khawaja et al., 2022). Participants had some difficulty in engaging in abstract symbols such as the tree. This may be due to a different style of thinking or cultural factors which require further investigation (Murman, 2015). However, this did not limit engagement, and participants continued to participate in the sessions and embraced drawing and the process overall. Consistent with previous research with this modality, sessions were completed successfully, and participants reported satisfaction with TOL (Jacob et al., 2018; Vitale et al., 2019).

TOL assisted participants in exploring and enriching alternative stories and self-narratives, consistent with previous research with refugees (Schweitzer et al., 2014; Vitale et al., 2019). For some participants, outsider witnesses allowed their self-narratives of being loving and nurturing carers to be heard and validated, strengthening their preferred self-narratives (Carey & Russell, 2003). When a participant became distressed, the group appeared to serve as a containing environment for her pain to be acknowledged. The group also acknowledged the strength she displayed, which appeared to soothe the participant and help her develop a self-narrative around her strengths. By comforting the distressed participant, it is likely that the other participants felt empowered by being able to help someone else (Van der Kolk, 2003).

Group cohesion also played an important role. An increasing sense of cohesion was observed in all members as the group progressed, evidenced by their increasing levels of contribution to the group, their interest in other members' stories, and offers of support to other members. By the third week, it appeared that participants became aware that others were interested in hearing what they said. This helped foster a sense of belonging, which was evidenced by participants' feedback regarding feeling respected and connected with other group members. This sense of belonging may be especially important considering the high levels of mistrust and suspicion that can exist in refugee communities (Hirschberger, 2018). The sense of belonging in a community as a result of group cohesion can help restore social ties and improve self and collective worth (Hirschberger, 2018; Slewa-Younan et al., 2018).

With regard to instilling hope, participants considered hopes for their children and grandchildren as opposed to themselves. Instillation of hope appeared to manifest differently in the current study than in previous studies where participants' hopes and wishes were for themselves (Schweitzer et al., 2014). Having hopes and dreams for significant others was reasonable considering the important role family played in the participants' narratives. Age was another factor that could contribute to participants displaying more hope for their family than themselves. As a person ages, it is common for their family to become the most important social and support group (Świderska, 2014). This may be linked to Bosnian gender roles where women focus more on family than themselves (Franz, 2003).

Corrective emotional experiences can facilitate change by allowing individuals to experience a new way of interacting (Teyber, 2017). The action of being heard may be more conducive to therapeutic change than intellectual understanding or explanations of

what is being said (Teyber, 2017). At the focus group, participants indicated that they could not discuss their past and current lives with family and appreciated that TOL allowed them to consider and share their stories. They also reported feeling “peace” during TOL. This indicated that TOL had the capacity to provide a corrective emotional experience for participants.

Participants enjoyed sharing more about their present-day activities than their past. This was evidenced by their higher levels of engagement when sessions were focused on daily activities, skills, and important people in their lives. This finding is consistent with research encouraging clinicians to move beyond a focus on past trauma and use interventions that capture the present lives of individuals and their communities (Hynie, 2018). The current findings align with other research where a present focus is a culturally appropriate strategy (Summerfield, 1999; Tankink & Richters, 2007).

Participants’ focus on the present was a cultural strength and viewed as a healthy way of coping. Interestingly, at the focus group, participants reported that TOL allowed them to remember their past; however, the participants did not provide many details about their past during sessions. This suggests that TOL may have contributed to internal reflection of their past, but participants preferred to focus their resources on the present, similar to findings of Tankink and Richters (2007). Their tendency to focus on the present was also evidenced by their high scores on the measure of resilience, in which they all endorsed items that aligned with confidence, problem-solving skills, openness to adapt, and optimistic attitude towards resettlement.

Implications

This is the first study to explore the impact, acceptability, and feasibility of TOL with older Bosnian women from refugee backgrounds. A qualitative approach provided an understanding of participants’ experiences. The findings address gaps in the literature by highlighting a psychosocial intervention that contextualises the experiences of people from a refugee background while considering their identity, culture, strengths, and resilience (Silove et al., 2017).

TOL strategies may be more acceptable to individuals from diverse backgrounds than traditional therapeutic programs and can be a solution to cultural and language barriers (Kaplan et al., 2016; Satinsky et al., 2019). The facilitators’ approach of being curious, seeing clients as experts, and appreciating their past and present culture and values, enhances the intervention as culturally safe and sensitive (Silove et al., 2017). Further, it may act as a vehicle to promote the mental health of Bosnian communities resettled in Australia, who otherwise may avoid seeking help due to social stigma and fear of discrimination (Asgary & Segar, 2011; Jankovic et al., 2011; Kaplan et al., 2016; Shannon et al., 2015).

Limitations and Future Directions

Although the small sample size assisted in the exploration of acceptability and feasibility, future research should recruit a larger sample of former Bosnian refugees from different gender and age groups to examine the effectiveness of TOL in a robust manner. The interpreter in this study was already well known and trusted by participants, but was not a qualified and accredited interpreter. Future research should ensure that interpreters have additional training in the content of the intervention and assessment tools to ensure appropriate translation and fidelity. While it was known that participants had experienced war and were former refugees, the authors did not collect specific details about their war-related experiences and did not administer any trauma measures, as detailed assessment of psychopathology was outside the scope of this trial. More rigorous assessment of trauma could be conducted in future. While this study provided some insight into therapeutic processes during the intervention, that was not the main purpose of this research. Therefore, future research should explicitly examine these processes and narratives.

Conclusion

TOL is a feasible intervention with elderly Bosnian women from a refugee background and is appropriate for further efficacy testing and dissemination studies. It is an alternative option for clinicians working collectively with ageing refugees. At a broader level, the findings encourage the use of narrative therapy principles, where appropriate, as an alternative to traditional therapeutic approaches. The results imply that there is an ageing refugee population that appreciates TOL, and explicitly desires more psychosocial and community-based programs. Consequently, this group is likely be open to and benefit from other psychosocial programs and interventions in the future.

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